MAIL TO:
E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/PSYA

PRIOR AUTHORIZATION
PSYCHOTHERAPY ATTACHMENT

1. Complete this form.
2. Attach to PA/RF (Prior Authorization Request Form)
3. Attach physician prescription.
4. Attach additional information if necessary.
5. Mail to EDS

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
Last Name	First Name	MI	Medical Assistance Identification Number	Age

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PROVIDER INFORMATION

(6)	(7)	(8)	
Performing Provider Name	Performing Provider #	Performing Provider's Telephone Number	MSW MS MD PHD DO PSYCH Other: _____ Discipline (circle one)

(9)	(10)	(11)	(12)
Supervising Provider's Name	Supervising Provider's Number	Prescribing Provider's Name	Prescribing Provider's Number

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A. Diagnosis: Axis I: a)
b)
Axis II:
Axis III:
Axis IV: 1 2 3 4 5 6 7 8 9 0 (optional)
Axis V: (past year) (optional)

B. Date Treatment Began: _____

C. Diagnosed By: __ Clinical Exam __ Psychological Testing __ Other (specify): _____

D. Consultation: __ Yes __ No Did consultant see recipient? __ Yes __ No

E. Result(s) of Consultation: _____

F. Presenting Symptoms: _____

Severity: __ Mild __ Moderate __ Severe

G. Is the recipient's intellectual functioning significantly below average? __ Yes __ No

H. If yes to "G", what is the recipient's IQ score or intellectual functioning level? _____

I. Historical Data. Give relevant social and school history including development (if under 18), treatment history, past mental status, diagnosis(es), etc. (attach additional sheets if necessary):

J. Present GAF (DSM): _____ Is the recipient progressing in treatment? __ Yes __ No
If "no", explain:

K. Present mental status/symptomatology (include progress since treatment was initiated, or since last authorization):

L. Updated/historical data (family dynamics, living situation, etc.):

M. Treatment Modalities: __ Psychodynamic __ Behavior Modification __ Biofeedback
__ Play Therapy __ Other (specify): _____

N. Number of minutes per session: Individual: __ Group: ___ Family: ____

O. Frequency of requested sessions: __ monthly __ once/week __ twice/month __ other (specify): _____

P. Total number of sessions requested: _____

Q. Psychoactive Medication: __ Yes __ No Has there been a medication check in the past three months?
__ Yes __ No

Names and dosage(s): _____

R. Rationale for further treatment:

S. Goals/objectives of treatment:

T. What steps have been taken to prepare recipient for termination of treatment:

U. Do you see other family members in a separate process? If yes, give rationale for seeing multiple family members:

Signature of Performing Provider	Recipient Signature (optional)	Signature of Supervising Provider	Date

*The provision of services which are greater than or significantly different from those authorized may result in non-payment of the claim(s).